127

(3)

No. 08-1068

In The
Supreme Court of the United States

JOANNE GAGLIANO,

Petitioner,

v.

RELIANCE STANDARD LIFE INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF IN OPPOSITION

JOSHUA BACHRACH
Counsel of Record
WILSON, ELSER, MOSKOWITZ,
EDELMAN & DICKER LLP
THE CURTIS CENTER
SUITE 1130 EAST
INDEPENDENCE SQUARE WEST
PHILADELPHIA, PA 19106
(215) 627-6900

Counsel for Respondent

April 30, 2009

Becker Gallagher · Cincinnati, OH · Washington, D.C. · 800.890.5001

CORPORATE DISCLOSURE STATEMENT

Respondent Reliance Standard Life Insurance Company hereby discloses that it is a subsidiary of Reliance Standard Life Insurance Company of Texas, which in turn is a subsidiary of Delphi Financial Group, Inc., which is a publicly held corporation.

TABLE OF CONTENTS

TABLE OF CITED AUTHORITIES

CASES

STATUTES

OTHER

ARGUMENT

I. Introduction

This lawsuit involves a claim for disability benefits under an ERISA plan.[1] Petitioner seeks review of the Fourth Circuit's decision to remand the claim back to respondent due to a procedural irregularity during the administrative review process. Petitioner argues that certiorari should be granted based on a split in the circuits on the proper remedy when a plan discontinues benefits through a defective procedure. According to petitioner, in other circuits, the remedy is to reinstate benefits. There is no split in the circuits on this subject.

Contrary to the position of petitioner, the cases she cites in her brief do not involve the same or similar facts to the ones in this case. In each of the cases relied on by petitioner from outside of the Fourth Circuit, there was no dispute that the claimant was eligible for benefits prior to the defective termination. Here, petitioner is attempting to obtain benefits under an ERISA plan without ever proving that she met the eligibility requirements. To the extent that the authority cited by petitioner can be stretched so thin as to cover the facts in this case, and if the Court then finds a split in the circuits, this is still not the appropriate case for this Court to resolve the issue. Therefore, the petition should be denied.

---

[1] The Employee Retirement Income Security Act of 1974

II. The Facts in this Case are Unique, Therefore, the Issue is different from the Cases Relied on by Petitioner

Petitioner suggests that there is a split in the circuits regarding the appropriate remedy when a claimant has not received a full and fair review of an adverse benefit determination as required under ERISA. This broad statement fails to recognize the unique facts that were presented to the circuit court in this case. Specifically, petitioner is relying on a procedural irregularity to continue to receive benefits that were improperly awarded and that she was never entitled to receive under the plain language in the Plan. None of the cases cited by petitioner involve these facts.

Petitioner stopped working in September of 2001 and submitted a claim for long term disability benefits under the Plan based on anxiety disorder and related symptoms. Pet. App. 3a. Because petitioner was not enrolled in the Plan for 12 consecutive months before claiming disability, her claim was subject to the Plan's pre-existing conditions limitation. Pet. App. 4a. During the initial claim process, petitioner completed a questionnaire in which she denied prior treatment for a similar condition. *Id.* Respondent promptly approved the claim and began paying disability benefits.

After paying benefits for several months, respondent notified petitioner that long term disability benefits were being discontinued based on updated medical information which did not support the claim that she remained disabled. *Id.* Petitioner administratively appealed the discontinuation of

benefits. During the appeal, respondent notified petitioner that it was scheduling an independent medical examination in accordance with the terms of the Plan. Pet. App. 28a. Instead of appearing for the independent medical examination, petitioner prematurely filed this lawsuit. *Id.*

Respondent filed a motion for summary judgment in the district court based, in part, on petitioner's failure to exhaust her administrative remedies as required under ERISA. Pet. App. 29a. The district court agreed that petitioner should have appeared for the independent medical examination and exhausted her administrative remedies before filing her lawsuit. *Id.* Accordingly, the district court remanded the claim to respondent to conduct an independent medical examination and "complete the administrative review process and render a final decision on plaintiff's administrative appeal." *Id.*

During the administrative appeal, respondent learned that the disability claim never should have been approved. Contrary to petitioner's response on the pre-existing condition questionnaire, petitioner was hospitalized for "stress syndrome/anxiety disorder" during the treatment free period before her individual coverage commenced. Pet. App. 6a. In fact, this hospitalization occurred just days before petitioner enrolled in the Plan. Pet. App. 27a. Because petitioner received treatment immediately before her effective date of coverage for a condition "which caused, contributed to or resulted in her eventual Total Disability . . ." respondent upheld the decision to discontinue benefits. Pet. App. 6a.

The district court's remand order, which preceded the second decision letter, required respondent to "render a final decision on [the] administrative appeal." Pet. App. 6a. Based on this language, the appeal denial letter did not include language regarding petitioner's appeal rights under ERISA. *Id.* Nevertheless, because the second decision letter included a new basis for the claim denial, respondent told counsel for petitioner that it "would be happy to consider any additional information" if permitted by the Court." Pet. App. 7a.

The Fourth Circuit ultimately concluded that respondent's offer to "consider any additional information" did not substantially comply with the requirements of ERISA. Pet App. 15a. However, the court of appeals reversed the judgment of the district court which ordered reinstatement as the remedy for the procedural violation. Pet. App. 16a-17a. Instead, the Fourth Circuit concluded that the proper remedy is to "remand the case to the plan administrator for a full and fair review regarding the basis for the denial of the benefits in the Second Termination Letter." Pet. App. 24a.

Petitioner suggests to this Court that the Fourth Circuit's decision in this case conflicts with decisions from the Third, Sixth, Seventh, and Ninth Circuits. Contrary to this argument, none of the decisions cited by petitioner involve facts that are even remotely similar.

The Third Circuit easily found a procedural violation in *Grossmuller v. Int'l Union et al.*, 715 F.2d 852 (CA3 1983). There, the Plan failed to establish procedures, failed to identify the evidence it relied on

in terminating benefits, failed to notify the claimant of his right to examine evidence or present rebuttal evidence and violated its own past practice by allowing a third party to appear before the appeal committee. *Grossmuller*, 715 F.2d at 858. Because there was no dispute as to the claimant's eligibility prior to the improper discontinuation of benefits, the Third Circuit concluded that the proper remedy was to reinstate benefits from the time of the improper denial. *Id.*

The decision of the Sixth Circuit also involved the discontinuation of benefits that were previously approved. *See Wenner v. Sun Life Assur. Co.*, 482 F.3d 878 (CA6 2007). Like the Third Circuit in *Grossmuller*, the Sixth Circuit concluded that the denial of benefits did not comply with the requirements of ERISA. *Wenner*, 482 F.3d at 883. Unlike the case presently before this Court, there was no dispute in *Wenner* as to the correctness of the benefit payments prior to the discontinuation of benefits. Accordingly, the court ordered reinstatement of benefits. *Id.* The same facts were also present in *Schneider v. Sentry Group Long-Term Disability Plan*, 422 F.3d 621 (CA7 2005), which is relied on by petitioner.

The Ninth Circuit decision cited by petitioner differs even more from this case and the ones described above. *See Pannebecker v. Liberty Life Assur. Co.*, 542 F.3d 1213 (CA9 2008). *Pannebecker* did not involve a defective denial notice. The Court instead concluded that defendant failed to properly apply the Plan provisions and also failed to make a reasonable inquiry into the claim. *Pannebecker*, 542 F.3d at 1220-21. Based on this flawed review, the court ordered reinstatement of benefits.

Petitioner's case presents facts that are different from all of these cases. Based on the pre-existing conditions limitation in the Plan, respondent never should have approved the disability claim. Giving petitioner every benefit of the doubt, the Fourth Circuit remanded the claim to respondent so that petitioner will have the opportunity to submit evidence that the pre-existing conditions limitation does not apply to her claim. Pet. App. 24a. Petitioner is not satisfied with this remedy, however. Obviously, petitioner recognizes that there is no evidence that she can submit which will eliminate the lack of coverage based on the pre-existing conditions language in the Plan.

There is a significant distinction between a discontinuation of benefits based on a finding that the claimant is no longer disabled and a plan's realization that the claimant never met the eligibility requirements. In all cases, a claimant's eligibility must be based on the language in the plan documents.[2] There is no language in the ERISA statute that supports an award of benefits to an ineligible person because there was a procedural irregularity.[3] This is

---

[2] *See Gutta v. Standard Select Trust*, 530 F.3d 614, 621 (CA7 Cir. 2008); *Wal-Mart Stores v. Gamboa*, 479 F.3d 538, 543 (CA8 Cir. 2007); *High v. E-Systems, Inc.*, 459 F.3d 573, 580 (CA5 Cir. 2006).

[3] Petitioner argues that if a court orders reinstatement of benefits and it is ultimately decided that the payments are contrary to the plan language, the plan can recoup these payments if the plan documents include the proper language. Pet. Br. 18. Although a plan may include language permitting the recovery of erroneously paid benefits, the bigger issue tends to be the participant's dissipation of those funds before a judgment is entered. On the other hand, if the claim is remanded and the participant

the only case cited to this Court that involves these facts. Therefore, there is no split in authority and review by this Court is not needed.

III. The Third, Sixth, Seventh and Ninth Circuits Have Also Remanded Claims When Appropriate

Contrary to the impression left by petitioner, the above-noted circuits do not apply an inflexible rule when confronted with a procedural violation during the claim process. While it is true that in the single case from each circuit cited by petitioner the courts ordered reinstatement of benefits, in other decisions from those same circuits the claims were remanded. These differing decisions demonstrate that courts award an appropriate remedy based on the facts of the individual case.

Petitioner refers this Court to the decision in *Grossmuller*, in which the Third Circuit ordered reinstatement of benefits after finding numerous procedural violations. *Grossmuller*, 715 F.2d at 858. However, the Third Circuit has not always concluded that reinstatement of benefits is the proper remedy when a plan fails to provide a full and fair review. *See Syed v. Hercules, Inc.*, 214 F.3d 155 (CA3 2000). In *Syed*, disability benefits were paid for two years before the claimant was notified that benefits were terminated. The claimant argued that the denial letter did not comply with ERISA's notice

---

ultimately proves eligibility for benefits, there is no harm by the delay in payment. As petitioner recognizes, a court can award pre-judgment interest. Pet. Br. 19.

requirements. Although the court disagreed with the plaintiff's argument, then Circuit Judge Alito stated that "the remedy for a violation of Section 503 is to remand to the Plan Administrator so the claimant gets the benefit of a full and fair review." *Syed*, 214 F.3d at 162.

The Sixth Circuit is no different. In *Wenner*, the court concluded that reinstatement of benefits was the appropriate remedy for the procedural violation. *Wenner*, 482 F.3d at 883. A different result was reached by the same court in *McCartha v. National City Corp.*, 419 F.3d 437 (CA6 2005). In *McCartha*, the disability plan paid benefits for several months before sending a termination letter. The Sixth Circuit determined that the Plan was not in substantial compliance with Section 503 of ERISA because it failed to provide the participant with one of the reasons for terminating benefits. *McCartha*, 419 F.3d at 447.

Unlike *Wenner*, the Sixth Circuit did not order reinstatement of benefits in *McCartha*. It did not even remand the claim for further review by the Plan. The Court held that a remand to the Plan would be a "useless formality" because the claimant could not produce additional evidence proving that the one basis for denying benefits that was properly communicated to the claimant was arbitrary and capricious. *McCartha*, 419 F.3d at 447. Contrary to the position advanced by petitioner, in affirming the judgment in favor of the Plan, the Sixth Circuit in *McCartha* stated that a "procedural violation does not require a substantive remedy." *Id.*

Petitioner also refers to the Seventh Circuit's decision in *Schneider*, in which the court ordered

reinstatement of benefits based on the failure of the denial notice to comply with ERISA. In other cases, the Seventh Circuit concluded that the appropriate remedy was to remand the claim to the plan for further review. *Wolfe v. J.C. Penny Co.*, 710 F.2d 388 (CA7 1983); *Quinn v. Blue Cross and Blue Shield*, 161 F.3d 472 (CA7 1998). In Quinn, the Seventh Circuit stated that "[a]warding retroactive benefits is not always the proper remedy . . . ." *Quinn*, 161 F.3d at 477.

Petitioner may argue that *Quinn* is distinguishable because it involved the Plan's failure to make adequate findings. Such a distinction is irrelevant. The ERISA statute does not discriminate in this matter. It broadly states that a plan must provide a "full and fair review" of an adverse decision. 29 U.S.C. § 1133(a).

The Ninth Circuit has also ordered different remedies for a procedural violation. In *Pannebecker*, the Plan discontinued benefits after it concluded that the claimant was no longer disabled. The district court initially concluded that the defendant failed to properly apply the terms of the Plan and remanded the claim for further review. On remand, the Plan again concluded that the claimant was not entitled to additional benefits. *Pannebecker*, 542 F.3d at 1215. This time, the district court upheld the denial of benefits. *Id.* On appeal, the Ninth Circuit held that the district court should have ordered retroactive reinstatement of disability benefits from the time of

the defective denial until the post remand decision.[4] *Pannebecker*, 542 F.3d at 1220-21.

In other cases in which the defendant has misconstrued the terms of the plan, the Ninth Circuit has ordered a remand rather than reinstatement of benefits. *See Saffle v. Pacific Power Co.*, 85 F.3d 455, 461 (CA9 1996). ("We now make explicit, that remand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator with discretion . . . has misconstrued the Plan and applied a wrong standard to a benefits determination."). *See also Chuck v. Hewlett Packard Co*, 455 F.3d 1026 (CA9 2006).

Even the Fourth Circuit, where this case originated, has not always remanded claims for further review after finding a procedural violation. *See Weaver v. Phoenix Home Life Mutual Ins. Co.*, 990 F.2d 154 (CA4 1993). The Fourth Circuit explained that "a remand for further action is unnecessary" where the evidence clearly establishes that the defendant abused its discretion. *Weaver*, 990 F.2d at 159. This argument cannot be made in petitioner's case, however.

Contrary to the basis for the petition presently before this Court, the cases cited above show that courts do not automatically remand claims for further review or automatically reinstate benefits depending

---

[4] It is odd, to say the least, that the Ninth Circuit upheld the Plan's conclusion that the claimant was not disabled when the benefits were originally terminated but retroactively awarded a portion of the disputed benefits to the claimant based on a procedural violation.

on the circuit. Courts instead look to the specific facts in a particular case before deciding the appropriate remedy. Simply put, there is no split in the circuits. Rather, there are different decisions in each circuit based on the facts that are presented.

IV. The Facts of This Case Make It Inappropriate for Review

To the extent that a split in the circuits can be found, this not the appropriate case to resolve the issue. This case does not involve an innocent plan participant who was misled by the plan. It involves a claimant who provided inaccurate information regarding her medical history to the Plan on a pre-existing conditions questionnaire. Pet. App. 27a. Additionally, petitioner's treating therapist failed to mention a "serious hospitalization" during the treatment free period in which petitioner received mental health treatment for the same condition on which she bases her disability claim. JA 886. In a hearing before the district court on October 20, 2003, before the district court reconsidered the ruling entered on that date, the judge recognized that the therapist's reports failed to "mention several key facts which would have . . . clearly put the insurance company on clear and fair notice of the pre-existing condition . . . ." JA 905-906. No new evidence was presented on reconsideration that could alter that conclusion.

Petitioner also interfered with respondent's investigation of the claim, and the applicability of the pre-existing conditions limitation, when she prematurely filed this lawsuit in an effort to avoid appearing for an independent medical examination.

Pet. App. 28a-29a. Significantly, when the independent medical examination finally took place pursuant to an order of the district court, the doctor clearly linked petitioner's hospitalization immediately before she became insured under the Plan to her disability claim several months later. JA 1068-1071.

After concluding that respondent did not provide petitioner "with the proper appeals notice required by ERISA in the Second Termination Letter," the Fourth Circuit remanded the claim to the Plan for a full and fair review of the denial based on the pre-existing conditions limitation. Pet. App. 21a. According to this limitation in the Plan, benefits are not payable for a disability based on a pre-existing condition, which is defined as "any Sickness or Injury for which the Insured received medical treatment, consultation, care or services . . . during the three months immediately prior to the Insured's effective date of insurance." Pet. App. 4a. The goal of the Fourth Circuit was for there to be a decision based on the merits and the Plan language after petitioner received a "full and fair review." Petitioner does not want that to happen. She wants a court to award benefits based on a technicality and without regard to her actual eligibility. Based on petitioner's own actions during the claim process, this request is especially unwarranted.

CONCLUSION

For the reasons stated above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

JOSHUA BACHRACH
Counsel of Record
WILSON, ELSER, MOSKOWITZ, EDELMAN & DICKER LLP
The Curtis Center, Suite 1130 East
Independence Square West
Philadelphia, PA 19106
(215) 627-6900